STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	012130	A. BUILDING: _____ B. WING _____	05/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERCREST SPECIALTY HOSPITAL	1625 E JEFFERSON BLVD MISHAWAKA, IN 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS HFAP Surveyor: 33212 Facility Number: 012130 Type of Survey: State Licensure Off Site HFAP Accreditation Survey Date of HFAP On Site Survey - Hospital full survey 1/22/2014 Date of ISDH off site review - 5/2/2014 Reviewer/Surveyor Nancy Otten RN, PHNS Based on review of the 1/22/2014 HFAP Accreditation Survey Report, it has been determined that Rivercrest Specialty Hospital meets the requirements for Hospital Licensure in Indiana for2014.	S 000		